STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to post the recent survey results or the location of the results for 2 of 4 days of the survey. Findings included: Observation and record review of the black binder	F 167	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the	10/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 167	Continued From page 1 on 9/18/19 at 10:30 AM located near the receptionist desk which contained the facility's survey results revealed statement of deficiencies (SOD) and plans of correction (POC) for a revisit survey on 3/3/17, a complaint survey dated 2/18/17 and a recertification survey and complaint dated 1/27/17. The binder did not contain the SOD and POC for the complaint survey dated 8/7/17. Observation and record review on 9/19/19 at 1:30 PM of the black binder continued to not contain the SOD and POC for the complaint survey dated 8/7/17. Interview on 9/19/17 at 2:41 PM with the Administrator revealed she was responsible for maintaining the survey book and she filed the SOD and POC in another binder which contained the facility's supporting evidence of compliance located in her office.	F 167	specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F 167	

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F 167	Continued From page 2	F 167	The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation Center regarding the process that lead to this deficiency was facility failed to follow established policy. On 09/21/17, the administrator posted the most recent statement of deficiency (SOD) and plan of correction (POC) for survey dated 8/7/17 in the survey binder located by reception desk. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/5/17, the facility consultant in-serviced the administrator that the facility must post in a readily accessible area to residents, family members, and legal representatives of residents the results of the most recent survey of the facility. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing (DON), or administrator will audit the survey binder 5 times weekly x 12 weeks beginning 10/15/17 to ensure the most recent survey is readily accessible to residents, family members, and legal representatives of	

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F 167	Continued From page 3	F 167	residents. This audit will be completed using the Survey Notebook Audit tool. The administrator will present all findings at the monthly Quality Improvement (QI) committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for continued monitoring and sustaining compliance. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing the plan of correction and follow-up on the Executive QI Committee recommendations.	
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 221		10/18/17

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F 221	Continued From page 4 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide a medical diagnosis to justify the use of a winged mattress for 2 of 2 residents in the sample who had a winged mattress applied to their bed. (Resident #13 and Resident #3) Findings included: 1. Resident #13 was admitted to the facility on 12/03/2010 with multiple diagnoses which included dementia and anxiety disorder. A review of the Quarterly Minimum Data Set (MDS) assessment dated 07/19/17 revealed Resident #13 was severely cognitively impaired. The resident was noted to be coded as total dependency on 2 people for bed mobility. Transfer was coded as requiring extensive assistance of one person. The MDS assessment was not coded for the use of restraints. A review of Resident #13's care plan revised 08/01/2017 revealed a goal that the resident	F 221	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. Pine Ridge Health and Rehabilitation	

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F 221	Continued From page 5 would be free from serious injury related to falls. The interventions listed included in part a low bed with a high winged mattress and a floor mat. The high winged mattress was initiated as far back as 11/07/2011. An observation on 09/19/17 at 09:50 AM revealed Resident #13 was observed lying on the winged mattress and scooped down into the bed. The winged mattress had a raised perimeter that cradled Resident #13. Again, on 09/19/17 at 1:00 PM Resident #13 was observed lying on the winged mattress and scooped down into the bed. Interview on 09/19/17 at 1:15 PM with the MDS coordinator revealed Resident #13 could unsafely get out of bed onto the floor mat with a standard mattress on the bed. Further interview revealed since the use of the winged mattress Resident #13 had not fallen, nor had a restraint assessment been done. Review of the paper and electronic medical record revealed no assessment for the use of a physical restraint. Interview on 09/19/17 at 1:37 PM with Medication Aide #1 (MA) who stated Resident #13 can get out of bed independently when she used a regular mattress on the bed but now that she had the new mattress (referring to the winged mattress) she could not get up on her own. During the interview MA #1 stated now staff had to transfer Resident #13 out of bed. Observation of Resident #13 and interview with Nursing Assistant #1 (NA) on 09/20/17 at 10:03 AM was completed. NA #1 indicated Resident #13 was capable of moving and transferring herself out of bed from the bed with a regular mattress and that the winged mattress was used to prevent her from getting out of bed. Resident #13 was requested several times by NA #1 to	F 221	Center acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 221 The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency was facility failed to follow established facility policy. On 9/19/17, the Minimum data set nurse (MDS) competed a physical restraint evaluation, which includes medical diagnosis to justify the use of a winged mattress, for Resident # 13.	

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F 221	Continued From page 6 move out of the bed while lying on the winged mattress and the resident would not respond. NA #13 indicated Resident #13 tried to get out of bed when agitated and today she was not agitated. Interview on 09/20/ 17 at 12:15 PM with the MDS coordinator, three (3) corporate representatives, the Director of Nurses (DON) and the Administrator was conducted. The DON indicated the winged mattress was not a restraint but a perimeter device to keep the resident from rolling out of bed. The administrator stated her expectation was for an assessment be conducted prior to the use of a restraint. 2. Resident #3 was admitted to the facility on 10-22-15. The resident remained in the facility. Resident #3 was admitted with multiple diagnoses including Alzheimer's, urinary tract infection, chronic kidney disease stage 3 and hypertension. A review of the Minimum Data Set (MDS) dated 7-27-17 revealed that resident #3 was cognitively impaired. The resident was noted to be coded as an extensive assist with 2 people for bed mobility and transfers and locomotion was coded as extensive assistance with one person. The MDS also coded restraints as none. A review of resident #3's care plan dated 7-27-17 revealed a goal that the resident would be free from falls. The interventions listed were that the resident would have a low bed air mattress with one side of the bed against the wall, the staff would follow the fall risk protocol and monitor routinely and that the resident would have a personal as well as a bed alarm. A review of the fall risk assessment dated 7-27-17 revealed that resident #3 was not a fall risk. There were no other fall risk assessments documented in the electronic medical record. An observation of resident #3 occurred on	F 221	On 10/12/17, the director of nursing (DON) competed a physical restraint evaluation, which includes a medical diagnosis to justify the use of a winged mattress, for Resident # 3. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 9/22/17, the geriatric care assistant competed a 100% audit of residents, noting residents on winged mattresses. All residents on winged mattress had a physical restraint evaluation completed by DON by 10/12/17, which includes a medical diagnosis to justify the use of a winged mattress. On 9/20/17, the DON initiated an in-service for all nursing staff on completing a physical restraint evaluation per facility policy. The in-service will be 100% complete by 10/14/17. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, treatment nurse, or MDS nurse will audit 25 residents weekly x 12 weeks for use of winged mattress (restraint) and appropriate documentation including medical diagnosis to support use. This audit will be completed using the winged mattress audit tool. The administrator will present all findings at the monthly Quality Improvement (QI) Committee meeting monthly for 3 months for review and recommendations for any	

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F 221	Continued From page 7 9-20-17 at 9:50am. The resident was observed being placed into a wing mattress. An interview with the nursing assistant (NA) occurred on 9-20-17 at 10:40am. The NA stated that resident #3 was able to get out of a regular hospital bed on her own and "for the resident safety she was placed in this type of bed". The NA was noted to touch the top part of the wing mattress. The NA also stated that the resident was not able to get out of the wing bed on her own. An interview with the Administrator occurred on 9-20-17 at 1:25pm. The Administrator stated she had not been able to find out when resident #3 received the wing bed. The Administrator stated the resident's care plan had resident in a low air mattress bed. An interview with the supply manager occurred on 9-20-17 at 2:40pm. The supply manager stated he would not know when the resident received the wing bed because "hospice ordered the bed". An interview with the facilities corporate nurse occurred on 9-20-17 at 3:08pm. The corporate nurse stated that resident #3 received the wing mattress before she was placed on hospice services but that the facility could not find any record as to when the resident received the bed or who ordered the wing bed. Interview on 09/20/ 17 at 12:15 PM with the MDS coordinator, three (3) corporate representatives, the Director of Nurses (DON) and the Administrator was conducted. The DON indicated the winged mattress was not a restraint but a perimeter device to keep the resident from rolling out of bed. The administrator stated her expectation was for an assessment be conducted prior to the use of a restraint.	F 221	modification of the monitoring process. The Administrator will present all findings at the next quarterly Executive QI Committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing this plan of correction and following up on the Executive QI Committee recommendations.	
F 241	483.10(a)(1) DIGNITY AND RESPECT OF	F 241		10/18/17

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F 241 SS=D	Continued From page 8 INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide a dignified dining by allowing Resident #3 to eat pureed foods with her fingers and staff standing over Resident #3 when fed. This was evident in 1 of 3 meals observed. Findings included: Resident #3 was admitted to the facility on 10/22/17 with current diagnoses of Alzheimer's disease. A review of Resident #3's Quarterly Minimum Data Set (MDS) dated 07/27/17 revealed Resident #3's cognition was severely impaired. The resident required extensive assistance of one person with eating. During a dinner observation on 09/18/17 at 6:10 PM revealed Resident #3 was observed eating her pureed dinner with her fingers. Continued dinner observation on 09/18/17 at 6: 20 PM revealed Nurse # 5 was observed standing over the resident while feeding her. During an interview with Nursing Assistant (NA) #4 on 09/19/17 at 4 PM who revealed that she	F 241	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. F 241 – Dignity and Respect of Individuality The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation Center regarding the process that lead to this deficiency was facility failed to follow established facility procedure for providing a dignified dining	

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F 241	Continued From page 9 passed out the dinner tray to Resident #3. Continued interview with NA #4 who stated she left Resident #3 after the tray set up because her intentions were to come back and assist her with eating. NA #4 stated it was difficult to assist all residents with eating because the facility did not have enough staff. During an interview with Nurse # 5 on 09/19/17 at 5 PM, who indicated she was aware of sitting in a chair while feeding but she was just helping NA #4 feed Resident # 3. During an interview with the Director of Nursing (DON) on 09/20/17 at 4 PM who stated her expectations included staff to sit down while feeding a resident and not allow residents to eat pureed foods with their fingers. During an interview with the Administrator on 09/20/17 at 4:10 PM she indicated that her expectation was for all residents to be treated with dignity and respect during all meals.	F 241	experience. On 10/9/17, Resident # 3 was provided with assistance from nursing assistant for breakfast meal which was observed by DON to ensure the resident was not eating pureed food with their fingers and staff was sitting while assisting resident with meal intake to provide a dignified dining experience. No negative finding noted during observation. Nurse # 5 and NA # 4 were in-serviced by the director of nursing by 10/14/17 on assisting residents with meal intake to ensure a dignified dining experience to include siting when assisting a resident to eat. On 10/5/17, the director of nursing (DON) initiated an in-service for all nursing staff on assisting residents with meal intake to ensure a dignified dining experience. The in-service will be 100% complete by 10/14/17. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/6/17, the facility consultant completed a 100% of audit of the most recent closed minimum data set assessments (MDS) to identify residents requiring limited, extensive, or total assistance with eating. On 10/9/17, the DON and/or licensed nurses competed a 100% audit of the breakfast meal to ensure residents	

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F 241	Continued From page 10	F 241	requiring limited, extensive, or total assistance with eating were receiving assistance to ensure dignified dining. No negative findings were noted. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning on 10/15/17, the DON, treatment nurse, or MDS nurse will observe 25 residents weekly x 12 weeks for dignified dining. This audit will be completed using the Dining Audit tool. Any instances of undignified dining observed will be immediately corrected by the auditor and noted on the Dining Audit tool. The administrator will present all findings at the monthly Quality Improvement (QI) Committee meeting monthly for 3 months for review and recommendations for any modification of the plan of correction and/or monitoring process. The administrator will present all audit findings and QI Committee recommendations at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing this plan of correction and follow-up on the recommendations made by the Executive QI Committee.	

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the cognition	F 278	F 278 □ Assessment Accuracy	10/18/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 status on the Minimum Data Set (MDS) assessment for 1 of 11 residents reviewed for accuracy. (Resident #12) Findings included: Resident #12 was admitted to the facility on 08/29/17 with cumulative diagnoses which included encephalopathy, type 2 diabetes mellitus and stage 3 chronic kidney disease. Review of the 5 day Minimum Data Set (MDS) assessment dated 09/05/17 indicated a BIMS (Brief Interview for Mental Status) score of 15 which represented Resident #5 was alert, oriented and accurate with answers without the need for cueing. Interview on 09/19/17 at 10:03 AM with Social worker (SW) #1 who stated Resident #12 could not understand the questions or what she was saying. SW #1 stated Resident #12's wife prompted, cued, and assisted him to answer the questions appropriately. Continued interview revealed Resident #12 had a difficult time with recall but required no cueing from the SW. Further interview with the SW revealed she made a mistake coding the MDS assessment dated 9/5/17 because Resident #12 did require constant cueing to answer the questions. Interview on 09/19/17 at 10:20 AM with the Director of Nurses (who was the nurse assigned to the resident on 9/19/17) stated Resident #12 was confused when he was initially admitted and less confused now. Interview on 09/19/17 at 10:22 AM with Nursing Assistant (NA) #1 indicated on admission the resident was alert, confused, forgetful, and could not remember (for example why the call bell was activated by him or if he ate). Interview on 09/19/17 at 10:33 AM with NA #9	F 278	The plan for correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency was facility failed to follow established facility policy to ensure accurate resident assessment. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 09/11/17 Resident #12□s minimum data set (MDS) assessment dated 9/5/17 was modified to accurately code Resident # 12□s cognition status by the minimum data set nurse (MDS). On 09/19/17, the modified assessment was transmitted to the National Repository by the MDS nurse. On 09/19/17, the modified assessment was accepted by the National Repository. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; On 10/5/17, the social worker, MDS nurse, and director of nursing (DON) were in-serviced by the facility consultant related to accurately coding the MDS assessment, including the coding of cognitive status based on the RAI manual. On 10/9/17, the corporate facility	

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F 278	Continued From page 13 who stated the resident was "all over the place" (referring to his confusion and constant forgetfulness). An interview was conducted on 09/20/ 17 at 12:15 PM with the MDS coordinator, three (3) corporate representatives, the DON and the Administrator. The Administrator stated she expected the MDS assessment be accurate and reflect the resident's status.	F 278	consultant audited MDS assessments completed in the past 30 days to ensure resident cognitive status were coded accurately. No modifications were needed. The week of 10/15/17, the DON, administrator or MDS nurse will begin auditing MDS assessments for accurate coding of cognitive status using the MDS Audit Tool. 10% of completed MDS assessments will be audited weekly x 12weeks. The administrator will present all findings at the monthly Quality Improvement (QI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The Administrator will present all findings at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing the plan of correction and follow-up on the Executive QI Committee recommendations.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 282		10/18/17

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F 282	Continued From page 14 must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement planned fall interventions identified on the care plan for 1 of 3 residents who had repeated falls (Resident #10). Findings Included: Resident #10 was admitted to the facility on 11/8/16 and diagnoses included Alzheimer ' s disease, malignant neoplasm of the left kidney and renal pelvis and muscle weakness. A review of the progress notes and incident reports for the past 4 months (6/1/17 through 9/19/17) for Resident #10 revealed he had a history of falls. The last fall identified was 6/20/17. A quarterly minimum data set (MDS) dated 7/19/17 for Resident #10 identified that he was cognitively impaired and required extensive assistance with bed mobility, transfers and toileting. A care plan for Resident #10 dated 8/2/17 revealed he was at risk for falls characterized by history of falls, actual falls and injury. Multiple risk factors related to impaired cognition, impaired mobility and poor safety awareness. Interventions included provide resident with a urinal and offer to assist him to use it frequently. Keep urinal within	F 282	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F 282 The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency was facility failed to follow established facility policy and procedure. On 09/21/2017, the Minimum Data Set Nurse (MDS) reviewed Resident #10□s care plan and care guide. The MDS	

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F 282	Continued From page 15 reach. Educate staff that resident can and will use a urinal. Fall mat on the floor when resident is in bed, slide the floor mat under the bed when resident is up out of bed The care guide for Resident #10 was reviewed and stated to check resident frequently for incontinence as resident will attempt to get up without assistance if he is wet. Keep urinal within reach and offer assistance to use. Provide a floor mat beside of bed; slide floor mat under bed when resident is up in chair. An observation of Resident #10 on 9/19/17 at 9:44 am revealed he was lying on the top of his bed. No urinal was observed to be in the room. No fall mat was noted to be on the floor next to his bed or underneath his bed. An observation of Resident #10 on 9/20/17 at 10:30 am revealed he was lying on the top of his bed asleep. No urinal was observed to be in the room. No fall mat was noted to be on the floor next to his bed or underneath his bed. An interview on 9/20/17 at 10:45 am with NA #1 revealed she was familiar with Resident #10 and was his NA for the current shift. She stated that he went to the bathroom frequently and he was supposed to call for help because he had a history of falls. She added that he would often get up and go to the bathroom on his own. NA #1 stated he was supposed to have a urinal within his reach so he would use that and not try and walk to the bathroom. An observation was made of Resident #10 ' s room with NA # 1 and she confirmed that there was no urinal or fall mat in his room. NA #1 stated she thought he had a urinal in his room earlier in the day but wasn ' t	F 282	nurse ensured the care plan and care guide was accurate and up to date. The Resident #10□s care plan and care guide includes risk for falls focus with urinal in reach and fall mat beside bed as interventions. On 9/20/17, the nursing assistant placed Resident # 10□s urinal in reach and floor mat beside bed. On 10/9/2017, the corporate facility consultant reviewed the care plans and care guides for all residents identified through the MDS process with fall risk, ensuring resident care plans and care guides included appropriate interventions. On 10/9/17, the director of nursing (DON) audited all residents with interventions of urinal in reach and/or floor mat beside bed. The audit was completed to ensure these interventions were in place. On 10/9/17, the DON ordered 12 additional nonskid fall floor mats. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/5/17, the DON began in-servicing 100% of all nurses, medication aides, and nursing assistants related to following resident care plans and care guides to ensure each resident is provided quality care and safety is maintained. The in-servicing included keeping the urinal in reach and fall mat beside of bed when indicated on the care guide. In-service will be completed by 10/14/17. During	

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F 282	Continued From page 16 sure why the fall mat wasn ' t in place. She checked Resident #10 ' s care guide that was on the back of his door, which documented he should have a urinal and floor mat. She stated she would have to go get them. An observation of Resident #10 ' s room on 9/20/17 at 1:42 pm revealed resident was sitting up in a chair. A urinal was noted to be on the side rail of his bed and a fall mat was on the floor next to his bed. An interview on 9/20/17 at 1:46 pm with Med Aide #1 revealed that Resident #10 was incontinent and he was supposed to have a urinal available for him to use. An interview on 9/20/17 at 1:51 pm with Nurse #1 revealed that she was familiar with Resident #10. She stated he had episodes of being incontinent and would typically use the urinal if it was accessible to him. Nurse #1 added that Resident #10 had urinary frequency related to his diagnosis. She explained that he had a history of falls, but she wasn ' t sure about him using a fall mat. Nurse #1 proceeded to check Resident #10s room and confirmed that he was supposed to have a fall mat. An interview with the Director of Nursing (DON) on 9/20/17 at 2:00 pm revealed it was her expectation that Resident #7 had a urinal accessible to him and within his reach. She added that this was an intervention to help prevent further falls. The DON added his fall mat may have been being cleaned and hanging outside to dry. She stated the facility did not have extra fall mats available at this time. She did not provide an alternate device the staff should use	F 282	orientation of new employees, the DON/staff facilitator will educate nurses and nursing assistants on the importance of following resident care plans and care guides and the location of each form. . The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 10/14/17, the administrative nurses, DON, staff facilitator, and/or MDS nurse will begin utilizing the Care Plan/Guide audit tool to ensure care plans and care guides are being followed to include interventions required to assist with management of residents identified with fall risk interventions to include keeping urinal within reach and fall mat at bedside. These random audits of 25 of residents will be reviewed weekly x 12 weeks. The administrator will present all findings at the monthly Quality Improvement (QI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring. The title of the person responsible for	

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F 282	Continued From page 17 when the fall mats were being cleaned.	F 282	implementing the acceptable plan of correction. The administrator is responsible for implementing this plan of correction and follow-up with Executive QI Committee recommendations.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and complainant interview the facility failed to provide assistance for a resident who required extensive assistance with feeding for 1 of 1 residents (Resident #3). Findings included: Resident #3 was admitted to the facility on 1-22-15 and remained in the facility. The resident was admitted with multiple diagnoses which included Alzheimer's, dementia, urinary tract infection and chronic kidney disease. A review of the Minimum Data Set (MDS) dated 7-27-17 revealed that resident #3 was cognitively impaired. The resident was coded as an extensive assist with 2 people for bed mobility and transfers. Dressing, toileting and personal hygiene was coded as an extensive assist with one person physical assist. The resident was coded as needing limited assistance with one	F 312	F 312 – ADL Care Provided for Dependent Residents The plan for correcting the specific deficiency. The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency was facility failed to follow established facility procedure for providing assistance with daily living (ADL) care for dependent residents. On 10/9/17, the nursing assistant provided Resident #3 with breakfast assistance. The assistance was observed by the director of nursing (DON) to ensure Resident #3 received ADL assistance to maintain good nutrition. No negative findings were noted. All licensed nurses and nursing assistants were in-serviced	10/18/17

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F 312	Continued From page 18 person physical assist for eating. A review of resident #3's care plan dated 8-11-17 was completed. The resident will not demonstrate signs or symptoms of hunger through to the next review. The interventions included; assessing and providing food preferences, monitoring and recording percentage of meal intake, offering substitutions for any uneaten food, providing assistance with each meal and providing therapeutic/non-therapeutic supplements. An interview with the complainant occurred on 9-18-17 at 3:50pm. The complainant stated that resident #3 sits in the Geri chair all day in the hall with little interaction. The complainant stated she has been at the facility at supper time and had to help feed resident #3. The complainant stated the resident tries to eat on her own at times but has difficulty getting the food to her mouth. An observation of resident #3 occurred on 9-18-17 at 6:10pm. The resident was noted to be sitting in the hallway in her Geri chair leaned back at a 45 degree angle. There was a straight back chair noted to be next to the resident's chair. There was a tray table placed across the resident with the top of the tray table at the height of her nose. The resident's dinner tray was noted to be on the table with the cover removed from the main entrée, the silverware was noted to be wrapped in the resident's napkin on the left side of her tray and a straw in one of her drinks. Resident #3 was noted to be trying to sit herself up to reach her food but was unable to do so. The resident was also observed trying to eat her puree entrée with her hands. An observation of resident #3 occurred on	F 312	by the director of nursing by 10/14/17 on assisting residents with meal intake to ensure ADL assistance provided during the dining experience to include siting when assisting a resident to eat, proper positioning of resident and dining surface, providing assistance based on resident need, and providing correct utensils. On 10/5/17, the director of nursing (DON) initiated an in-service for all nursing staff on providing resident assistance with eating meals. The in-service will be 100% complete by 10/14/17. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/6/17, corporate facility consultant completed a 100% of audit of most recent completed MDS assessments to identify residents requiring ADL assistance. The residents who require limited, extensive, or total assistance with eating were included in the audit. On 10/9/17, the DON, and licensed nurses competed an observation with all residents requiring limited, extensive, or total ADL assistance with eating to ensure residents were receiving ADL meal assistance to maintain good nutrition. No negative findings were noted. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	

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F 312	Continued From page 19 9-18-17 at 6:20pm. The nurse for resident #3 approached the resident, unwrapped her silverware and fed the resident 3 bites of food standing over the resident then walked away. Resident was noted to continue to try to reach her food with her hands. An observation of resident #3 occurred on 9-18-17 at 6:35pm. The nursing assistant (NA) for resident #3 was noted to sit the resident up in the Geri chair, adjusted the tray table to the appropriate height then sat down next to the resident. The resident was fed at that time her whole supper. An interview with the nursing assistant (NA) occurred on 9-18-17 at 6:35pm. The NA stated that staff would typically set the residents tray up for the resident and see if the resident will eat on her own but if the resident does not eat on her own then staff would feed her. The NA stated she would have sat the resident up in her chair, made sure the resident could reach her food and hand the resident the spoon so the resident could try and feed herself. An observation of resident #3 occurred on 9-19-17 at 8:11am. The resident was noted to be in her Geri chair in the hallway being fed by one of the NA's. The resident was noted to be eating as long as the NA was assisting her. The resident's pureed food was noted to be mixed together. An observation of resident #3 occurred on 9-19-17 at 1:10pm. Resident was in the hallway sitting up in her Geri chair. The lunch tray was placed in front of her at an appropriate height and the resident was noted to be using a spoon to	F 312	Starting 10/15/17, the DON, treatment nurse, or minimum data set (MDS) nurse will observe 25 residents weekly x 12 weeks for ADL meal assistance when dining. This audit will be completed using the Dining Audit tool. Any observation of not providing ADL assistance with meals will be immediately corrected by the auditor. The administrator will present all audit findings at the monthly Quality Improvement (QI) committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. The administrator will present all findings at the next quarterly Executive QI Committee to discuss the QI process and/or any recommendations for continued monitoring and sustaining compliance in the area of ADL care provided for dependent residents. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing the plan of correction and follow-up on the Executive QI Committee recommendations.	

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F 312	Continued From page 20 feed herself. An interview with the nursing assistant (NA) occurred on 9-19-17 at 1:10pm. The NA stated that the resident "normally" did well to feed herself lunch but that she needed assistance for the other meals "because she is tired at those times". An interview with the Administrator occurred on 9-20-17 at 1:15pm. The administrator stated she expected that the resident would be able to reach her food, have the correct utensils within reach and the tray table to be at an appropriate height.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, complainant interview, resident interview and record review the facility failed to provide equipment to maintain range of motion for 2 of 3 residents (resident #1 and #11). Findings included:	F 318	F 318 □ Increase/Prevent Decrease in Range of Motion The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the	10/18/17

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F 318	Continued From page 21 1: Resident #1 was admitted to the facility on 9-8-08 and remained in the facility. The resident was admitted with multiple diagnoses to include cognitive communication deficits, difficulty walking, unspecified psychosis and dementia. A review of the Minimum Data Set (MDS) dated 6-29-17 revealed that resident #1 was cognitively impaired. Resident was coded as needing extensive assistance with 2 people for bed mobility. Transfers were coded as the resident was totally dependent with 2 people assisting. The MDS also revealed that she was coded to receive restorative care in the area of range of motion. A review of the nursing assistance care card revealed that the resident was to have a long pillow placed on the resident's right side and a curved back pillow placed against the residents back when she is sitting up in her chair. An interview with the complainant occurred on 9-18-17 at 3:50pm. The complainant stated she came to see the resident "just about every day" and that "more times than not" the residents therapeutic pillows are not placed in the chair with the resident. The complainant stated she would often find the back pillow on the bed of the roommate of the resident. An observation of resident #1 occurred on 9-18-17 at 3:50pm. The resident was noted to be sitting up in her recliner with the long pillow on her right side but the back pillow was laying on the resident's bed. The resident was noted to be leaning to the right. An observation of resident #1 occurred on	F 318	process that lead to this deficiency was facility failed to follow established facility policy to provide splints, range of motion, and positioning pillows per care plan. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/12/17, the nursing assistant placed Resident #1□s long pillow along resident□s right side and curved back pillow behind the resident□s back when Resident #1 was up in their chair. On 10/12/17, the director of nursing (DON) verified with therapy services Resident #11□s left hand splint schedule. On 10/12/17, the nursing assistant placed Resident #11□s left hand splint on at bedtime as Resident # 11□s care plan instructs. On 10/12/17, the restorative aid provided restorative range of motion based on the restorative care plan and documented in the Resident #11□s medical record. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; On 10/5/17, the DON initiated an in-service for all nursing staff on providing care and documentation according to the care plan/care guide including restorative care and use of positioning pillows. The in-service will be 100% complete by	

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F 318	Continued From page 22 9-19-17 at 12:06pm. Resident was noted to be sitting in her recliner leaning to the right side. The resident's back and long pillow were both placed behind the residents back. An observation of resident #1 occurred on 9-20-17 at 11:50am. The resident was noted to be sitting in her recliner. The resident's long pillow was noted to be placed correctly on the resident's right side however the residents back pillow was noted to be laying on her bed. An observation of resident #1 occurred on 9-20-17 at 12:20pm. Both of the resident's pillows were noted to be placed in the correct position. An interview with the nursing assistant (NA) occurred on 9-20-17 at 12:20pm. The NA stated that the resident's daughter told her how the pillows were to be placed but that she checked the resident's care card to make sure that was correct. The NA stated she would read the resident's care card "a couple times a week" to see if there were new orders. An interview with the nurse occurred on 9-20-17 at 12:25pm. The nurse stated that the resident had the 2 pillows to help position her in the recliner to prevent "strain and pain" to the resident's shoulder and neck. The nurse stated she would find the intervention of the pillows in the care card. An interview with the Director of Nursing (DON) occurred on 9-20-17 at 1:00pm. The DON stated she expected the nursing assistance to follow the care card and place the therapeutic pillows appropriately when the resident was sitting in her recliner.	F 318	10/14/17. On 10/12/17, the DON completed a 100% of audit of residents currently on the restorative nursing program to ensure care plans are current and match therapy referrals, including positioning pillows. The audit revealed no negative findings. The DON, treatment nurse, or MDS nurse will observe 25 residents weekly x 12 weeks to ensure the facility is providing restorative services and positioning pillows to prevent decrease range in motion or increase range of motion. This audit will be completed using the Restorative Audit tool. The administrator will present all findings at the monthly Quality Improvement (QI) Committee meeting monthly for 3 months for review and recommendations for any modification of the plan of correction and/or monitoring process. The administrator will present results of the audits and QI Committee recommendations at the next quarterly Executive QI Committee meeting to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing the plan of correction and follow-up on the Executive QI Committee recommendations.	

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2: Resident #11 was admitted to the facility on 6-18-2014. Resident remained in the facility. Resident #11 was admitted with multiple diagnoses which included hemiplegia left side, vascular dementia, contracture of the left hand, muscle weakness and aphasia.

A review of the Minimum Data Set (MDS) dated 7-24-17 revealed that the resident was cognitively intact. The resident was coded as an extensive assist with 2 people for bed mobility, total dependence with 2 people assist for transfers and total dependence with one person assist for personal hygiene. The MDS also revealed that the resident was to receive range of motion and a splint to his left hand.

A review of resident #11's care plan dated 7-24-17 had the goal "resident will not have further contractures of the left hand and wrist". The care plan revealed the intervention would be that the resident wear a splint to his left hand 4-6 hours or as tolerated at hours of sleep.

A review of the nursing assistant care card revealed that resident #11 was to have his splint placed to his left hand 4-6 hours at hours of sleep.

A review of Occupational Therapy (OT) documentation dated 6-13-17 revealed that resident #11 was discharged from OT and was admitted to the restorative nursing program.

An observation of resident #11 occurred on 9-19-17 at 8:40am. The resident was noted to be in the bed with his left hand on a pillow but there was no splint noted.

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An interview with the restorative nursing assistant occurred on 9-19-17 at 8:50am. The restorative nursing assistant stated that resident #11 was to wear his splint to his left hand at night when he was sleeping. The restorative nursing assistant also stated that she taught the night time nursing assistants how to apply the splint. The restorative nursing assistant could not locate documentation of the training she provided.

An interview with resident #11 occurred on 9-19-17 at 9:00am. The resident stated he had not worn his splint to the left hand at night when he sleeps but that the nursing assistants put the splint on him during the day. The resident stated he did not have a preference if he wore it at night or during the day. The resident also denied ever refusing to wear his splint.

An interview with the nursing assistant (NA) occurred on 9-19-17 at 11:30am. The NA stated that she had not put the resident's splint on his left hand because "I was told by therapy that they would put it on". The NA also stated that she had been working with resident #11 for almost a year and had never put his splint on his left hand.

A request was made to the restorative nurse on 9-19-17 to provide documentation of when the splint was applied, removed and how the resident tolerated having the splint to his left hand applied. The restorative nurse was unable to locate any documentation to reflect the requested information.

An interview with the Director of Nursing (DON) occurred on 9-20-17 at 9:25am. The Don stated that the documentation of when resident #11 had

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his splint on, when it was removed and how he tolerated having his splint on his left hand would be found in the electronic medical record under the nursing assistant tasks. The DON was not able to find any information regarding when resident #11 had the splint applied to his left hand, when it was removed or how the resident tolerated having the splint on his left hand in the electronic medical record. The DON stated that the resident would have the splint applied on "night shift".

An interview with resident #11 occurred on 9-20-17 at 9:40am. The resident stated he did not have his splint on his left hand last night "because they could not find it". The resident stated he could not locate the splint. The resident stated he had his splint yesterday on his night stand and did not know what happened to it.

An observation of resident #11 occurred on 9-20-17 at 11:55am. The resident was noted to be sitting in the hall in his wheelchair. The resident was not wearing his splint to his left hand.

An interview with resident #11 occurred on 9-20-17 at 11:55am. The resident stated that staff had not located his splint for his left hand.

An interview with the Administrator occurred on 9-20-17 at 1:30pm. The Administrator stated she expected that staff would document daily when they applied the splint, when they removed it and how the resident tolerated having the splint applied. The Administrator also stated she expected the resident to have his splint and it be applied as it was ordered.

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F 353	Continued From page 26	F 353		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		10/18/17

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F 353	Continued From page 27 (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, family interviews, staff interviews and record review the facility failed to provide nursing staffing of sufficient quantity and quality to provide the required assistance needed with eating for 1 resident (Resident #3), apply equipment as ordered to maintain range of motion for 2 residents (Resident # 1 and Resident #11) and provide a dignified dining experience for 1 resident (Resident #1) for 3 of 7 residents that were dependent for care. Findings Included: This tag is cross referenced to: 1. F-312 Based on observation, staff interview and complainant interview the facility failed to provide assistance for a resident that required extensive assistance with feeding for 1 of 1 residents (Resident #3). 2. F-318 Based on observation, staff interview and complainant interview, resident interview and record review the facility failed to provide equipment to maintain range of motion for 2 of 3 residents (Resident #1 and Resident #11).	F 353	Pine Ridge Health and Rehabilitation Center acknowledges receipt of The Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 353 The plan of correcting the specific	

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F 353	Continued From page 28 3. F-241 Based on observations, record reviews and staff interviews the facility failed to provide dignified dining by allowing Resident #3 to eat pureed foods with her fingers and staff standing over Resident #3 when she was fed. This was evident in 1 of 3 meals observed. An observation of the facility on 9/17/17 at 9:00 pm revealed there were was 1 nursing assistant (NA) present to care for 27 residents residing on the 100 hall. There was 1 NA present to care for 30 residents on the 200 hall. There was 1 NA present to care for 20 residents on the 300 hall and 1 NA present to care for 27 residents on the 400 hall. A NA assigned on 09/17/17 to float between the 100 and 200 hall was not located in the facility at 9:00 pm or observed to be in the facility through 11:00 pm. An interview on 9/18/17 at 12:27 am with NA #7 assigned to the 100 hall stated she was the only NA for the hall and had 27 residents to care for. She explained that she did the best she could to just get her rounds done, keep the residents turned and repositioned and answer the call lights as quickly as she could. The NA stated that there just wasn ' t enough staff to take care of the residents the way they should. She added that a few months ago she had to cover the 100, 300 and 400 halls on third shift because there was no other NA ' s there. She went on to say that she frequently had to pick up the 300 hall as well as her 100 hall assignment because the NA for the 300 hall wasn ' t there for the full shift. The NA explained that she typically had 4 showers to do on her shift and sometimes the first shift staff would get upset because she didn ' t have all the residents up and ready for their breakfast meal	F 353	deficiency The position of Pine Ridge Health and Rehabilitation Center regarding the process that lead to this deficiency was the facility failed to assess resident needs to provide sufficient 24 hour nursing staff per care plans. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/9/17, the nursing assistant provided breakfast assistance to Resident # 3 according to the care plan to provide a dignified dining experience. The assistance provided was observed by the director of nursing (DON). On 10/12/17, the nursing assistant placed Resident # 1□s long pillow along the resident□s right side and curved back pillow behind the resident□s back when Resident #1 was up in their chair. On 10/12/17, the DON verified with therapy services Resident # 11□s left hand splint schedule. On 10/12/17, the nursing assistant placed Resident # 11□s left hand splint on at bedtime as Resident # 11□s care plan instructs. On 10/12/17, the restorative aid provided restorative range of motion based on the restorative care plan and documented in the resident medical record. On 10/12/17, the DON and administrator reviewed the staffing schedule for 10/11/17 and 10/12/17 to ensure sufficient numbers of staff to provide nursing care	

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F 353	Continued From page 29 but she just couldn ' t get it all done. She added that sometimes there was only 1 NA on the first shift as well. An interview on 9/18/17 at 12:40 pm with NA #4 stated that she just does the best she can when she is the only NA on the hall. She added she guessed she had gotten used to it because you never knew if there would be enough people on the schedule or if they would come to work. The NA stated she tries, but that the residents probably don ' t get the care they deserve when they are short staffed. An interview on 9/19/17 at 10:00 am with NA #8 stated she had been at the facility about a year and typically worked first shift. She explained there were 2 NAs on her hall and they had an assignment of 15 residents each. The NA added they really needed a third person because most of the residents needed total care and were incontinent. She stated she did the best she could to meet the resident ' s needs but sometimes the residents did have to wait for care because there were only 2 NAs on the hall. A phone interview on 9/19/17 at 11:10 am with Nurse #3 stated she typically worked third shift and had been at the facility for about 2 years. She explained that when she first worked here there were always 2 NAs on the 500 hall (dementia unit) but now there was usually only 1 NA on the 500 hall and that NA also had to care for the 5 rest home residents. The nurse added that there was typically one NA per hall on third shift but often there was no NA available for the 300 hall and the other 3 NA ' s had to split the assignment up for that hall. She stated that would give the NAs 37 or 38 residents to take care of.	F 353	to all residents to include providing assistance with daily living (ADL) care for residents including feeding, to prevent a decrease/increase range of motion (ROM) including application of splints and providing ROM exercises, and providing dignity and respect including in the dining experience. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Beginning 10/15/17, the DON and/or administrator will complete the Sufficient Staff audit tool to monitor for sufficient staffing. The audit tool ensures staff will be scheduled to provide residents with ADL assistance that enable them to reach their highest practicable physical, mental, psychosocial well-being, including showers, timely call light response, completion and documentation of treatments, and timely medication administration. . The DON or administrator will utilize the Sufficient Staff tool five times weekly to include nights and weekends for 12 weeks. Any identified issues will be addressed immediately by the auditor. The administrator and/or the DON will present findings from the Sufficient Staff tool at the monthly quality improvement (QI) committee meetings for three months for review and recommendations for any modification of the plan of correction or monitoring process. The administrator will present all findings at the next quarterly	

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F 353	Continued From page 30 An interview on 9/20/17 at 9:32 am with the Director of Nursing (DON) revealed that the facility had hired additional staff but once they got through orientation they often didn ' t stay. She stated they had requested to utilize agency staffing when they were short staffed, but that had not been approved so far. The DON explained that her goal was to have 3 NAs per hall on first shift and second shift and 1.5 NAs per hall on third shift. She stated that with the current staffing she was typically only able to schedule 2 NAs per hall on first and second shifts and 1 NA per hall on third shift. The DON added that if they were below those numbers staff from other areas would come and help them, she was unable to explain where that other staff would come from. An interview on 9/20/17 at 4:22 pm with the Administrator revealed she expected that all halls were adequately staffed to provide the care the residents needed. She added that resident acuity would impact how much staff each hall would need.	F 353	Executive QI committee to discuss the quality improvement process and/or any recommendations for sustaining compliance. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementing this plan of correction and follow-up with Executive QI committee recommendations.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		10/18/17

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F 520	Continued From page 31 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews, family interview and record review, the facility ' s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/27/17 annual recertification survey. This was for recited deficiencies in the areas of assessment accuracy (F278) and services provided by qualified staff	F 520	An acceptable plan of correction must contain the following elements: " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

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F 520	Continued From page 32 per the residents care plan (F282). The facility ' s QAA committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the 8/7/17 complaint survey. This was for recited deficiencies in the areas of dignity and respect (F241), provision of activities of daily living (F312) and provision of adequate staffing (F353). The continued failure of the facility during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAA Program. Findings Included: This tag is cross referenced to: 1. F-278 Based on record review and staff interview the facility failed to accurately code the cognition status on the Minimum Data Set (MDS) assessment for 1 of 11 residents reviewed for accuracy (Resident #12). During the annual recertification survey of 1/27/17 the facility was cited for F-278 for failing to accurately code the minimum data set (MDS) for hospice services for 1 of 3 sampled residents and failing to accurately code dental status for 2 of 3 residents. 2. F-282 Based on observations, record review and staff interviews the facility failed to implement planned fall interventions identified on the care plan for 1 of 3 residents who had repeated falls (Resident #10). During the annual recertification survey of 1/27/17 the facility was cited for F-282 for failing to be able to identify medications that had been	F 520	" The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; " The title of the person responsible for implementing the acceptable plan of correction. F 520 QAA Committee The plan of correcting the specific deficiency The position of Pine Ridge Health and Rehabilitation center regarding the process that lead to this deficiency was failure to follow established facility policy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/12/17 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Medical Director, Administrator, DON, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QAA Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 10/5/17 the corporate facility consultant in-serviced the facility administrator, director of nursing,	

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F 520	Continued From page 33 crushed by a medication aide and then provided to a nurse to administer the medications via a gastrostomy tube for 1 of 1 resident that was observed for medication administration. 3. F-241 Based on observations, record reviews and staff interviews the facility failed to provide dignified dining by allowing Resident #3 to eat pureed foods with her fingers and staff standing over Resident #3 when she was fed. This was evident in 1 of 3 meals observed. During the complaint survey of 8/7/17 the facility was cited for F-241 for failing to provide a dignified dining experience by serving a resident (1 of 1 observed) a meal in an environment with an offensive odor (feces odor). The facility failed to provide glassware for residents who received an 8 ounce paper carton of milk during 2 of 2 meal observations. 4. F-312 Based on observation, staff interview and complainant interview the facility failed to provide assistance for a resident that required extensive assistance with feeding for 1 of 1 residents (Resident #3). During the complaint survey of 8/7/17 the facility was cited for F-312 for failing to provide incontinent care for 2 of 3 residents that were totally dependent on staff for incontinence care. The facility failed to provide assistance with feeding for 1 of 3 residents that was totally dependent on staff for eating. 5. F-353 Based on observations, resident interviews, family interviews, staff interviews and record review the facility failed to provide nursing staffing of sufficient quantity and quality to provide	F 520	admissions, activities director, maintenance director, dietary manager, therapy director, and housekeeping supervisor related to the appropriate functioning of the QAA Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F278- assessment accuracy, F282-provide services based on residents□ care plan, F241-dignity and respect, F312-ADL care, and F353-adequate staffing. As of 10/5/17 after the facility consultant in-service, the facility QAA Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The Facility QAA Committee will meet at a minimum of monthly and Executive QAA committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F278-assessment accuracy, F282-provide services based on residents□ care plan,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. BUILDING _____ B. WING _____	C 09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 34 the required assistance needed with eating for 1 resident (Resident #3), apply equipment as ordered to maintain range of motion for 2 residents (Resident # 1 and Resident #11) and provide a dignified dining experience for 1 resident (Resident #1) for 3 of 7 residents that were dependent for care. During the complaint survey of 8/7/17 the facility was cited for F-353 for failing to provide sufficient quantity and quality of staff to provide incontinence care and assistance with eating. An interview was conducted on 9/20/17 at 4:25 pm with the Administrator and Director of Nursing (DON). The Administrator stated that the facility Quality Assessment and Assurance Committee (QAA) met monthly. She stated the committee consisted of herself, the DON and the facility department managers. She added that quarterly the pharmacy consultant and medical director participated in the meetings. The DON stated related to the resident dignity issues that if a resident was using her fingers to eat her food and that was a normal routine for the resident, this should have been care planned. She added that the facility had discussed meal service and dignity to be sure all residents ' trays were delivered by table. The DON explained that they were completing audits to check that residents were not left soiled and were not double briefed. The Administrator added that the facility had completed 20 random audits every month to check for care and dignity areas such as hair care, oral care, nail care, shaving and appropriate clothing. The DON stated that the MDS nurse was responsible to ensure that coding was correct. The Administrator revealed she expected that all halls were adequately staffed to provide	F 520	F241-dignity and respect, F312-ADL care, and F353- adequate staffing. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAA committee will continue to meet at a minimum of Quarterly, and QAA committee monthly with oversight by a corporate staff member. The Executive QAA Committee, including the Medical Director, will review quarterly compiled QAA report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAA Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator or his designee will report back to the Executive QAA Committee at the next scheduled meeting.	

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F 520	Continued From page 35 the care the residents needed. She added that resident acuity would impact how much staff each hall would need.	F 520		